South Central Ambulance Service
NHS Foundation Trust

Risk Management Strategy

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Introduction

1.1 South Central Ambulance Service NHS Foundation Trust provides emergency and urgent care along with other non-emergency business such as patient transport services and NHS 111. The Trust provides these services across Hampshire, Berkshire, Oxfordshire, Buckinghamshire, Surrey and Sussex.

1.2 The delivery of health care and in particular the provision of Ambulance services will always involve a degree of risk, potentially such risks may be heightened during periods of demand and change management. The aim of this strategy is to ensure that such risks are identified, assessed, evaluated and minimised, and to ensure that when making decisions those doing so are deliberately choosing to make judgements from a range of fully detailed and understood options.

1.3 The Trust Board supports a just and fair culture and believes that staff should feel confident to report incidents and near misses openly. Learning will form the foundation of this risk management strategy and will be used in all risk management activities to improve the quality of its patient care services and also to eliminate and/or reduce risk to its patients, staff, and other stakeholders.

1.4 The Trust has adopted a holistic approach to risk management, making no segregation between clinical, non-clinical, financial or other risk.

1.5 The Risk management strategy provides a basis for a well-managed process to ensure safe services and an accurate record of risks. It will be reviewed on an annual basis and approved by the Trust Board. It will be published and made available to the Public and Stakeholders via the Trust's website. The Strategy will be communicated to staff in accordance with Corporate Policy & Procedure (CPP No.1) 'Trust Policies and Procedures – Implementation and Review'.

1.6 The Trust will work with stakeholders and commissioners to ensure that service provision is maintained and any risks are identified and dealt with through collaboration and joint working. The Trust will highlight risk with its stakeholders through the Corporate Risk Register and maintain a stakeholders' list.

1.7 **The Trust Board will be reviewing risk management/risk assurance arrangements in 2018.**

2. Scope

2.1 This Risk Management Strategy applies to all departments and all who work on behalf of or for the Trust.

3. Equality Statement

3.1 The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment and pregnancy/maternity or any other basis not justified by law or relevant to the

requirements of the post. The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees regardless of the afore mentioned protected characteristics, whether full or part time or employed under a permanent or a fixed term contract or any other irrelevant factor.

3.2 By committing to a policy encouraging equality of opportunity and diversity, the Trust values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service. The Trust is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.

3.3 Where there are barriers to understanding; for example, an employee has difficulty in reading or writing, or where English is not their first language, additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure. Further information on the support available can be sought from the Human Resources Department.

4. Aims

4.1 The aims of this strategy are to:

- integrate risk management into the Trust's culture and everyday management practice
- clearly define the Trust's approach and commitment to risk assurance and management
- raise staff awareness, knowledge and skills
- document responsibilities and a structure for managing risk
- ensure a co-ordinated, standard methodology is adopted by every directorate/ department
- encourage and support incident reporting in a 'fair blame' culture
- ensure that the Trust Chief Executive and Trust Board are provided with evidence that risks are being appropriately identified, assessed, addressed and monitored.
- adopt an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety or financial risk, through the processes and structures detailed in this strategy
- accept that whilst the provision of health care is not risk free, the Trust will aim to minimise the adverse effects of any risks
- to ensure that assurances on risk are provided to the Quality and Safety Committee and Audit Committee both of which are a sub committees of the Trust Board
- manage risk as part of normal line management responsibilities and provide funding to address 'risk' issues as part of the normal business planning process
- undertake suitable and sufficient risk assessments to ensure that:

  i. all significant hazards and risks and any associated controls are identified
  ii. risks are evaluated and rated i.e. given a risk score
  iii. where necessary, further control measures are implemented to minimise or eliminate the risks
  iv. risks are recorded on the Corporate Risk Register.

5. Objectives

The objectives of this strategy are:

- To ensure the Trust fulfils its legal and governance responsibilities
- To preserve and enhance the Trust's reputation
- To protect the assets and interests of the Trust
- To protect the interests of staff, stakeholders, patients and the public (i.e. all those affected by Trust business)
- To embed the concepts and ideas of risk assessment and risk management into the day to day working practices of the Trust.

5.1 **Specific Objectives 2018 - 19**

- To maintain links and consistency with the Trust's Integrated Performance Report
- Continue to develop and embed the Board Assurance Framework
- To self-assess performance against the relevant outcomes from the Essential Standards of quality and safety published by the Care Quality Commission and linking with the annual quality report inclusive of the quality accounts
- To identify and review strategic risks facing the organisation
- To continue to provide risk assessment training to managers and staff within the Trust
- To introduce a programme of training for managers and supervisors in risk management and root cause analysis (RCA)
- To further develop the web based risk management database (Datix) providing standardised reporting and information across the Trust
- Maintain the delivery of Healthcare Associated Infections (HCAI) Trust wide improvement plan for the management of infection prevention control and decontamination
- Maintain the safeguarding processes within the organisation (Child protection and Vulnerable adults)
- Continue to implement a programme of conflict resolution training (CRT) for all patient-facing staff in compliance with NHS Protect guidance
- To reduce serious motor vehicle accidents involving Trust vehicles
- To identify patient safety metrics and to monitor and benchmark ourselves against other Ambulance Trusts
- To continue to improve our quality and performance in relation to clinical effectiveness and outcomes
- To continue to develop and manage the Trust's information governance processes
- To meet the service improvements outlined in the 2017/18 Quality Accounts.

6. Roles and Responsibilities

6.1 Trust Board

6.1.1 The Trust Board has overall responsibility for having an effective risk management system in place within the Trust and for meeting all statutory requirements and adhering to guidelines issued by the Department of Health in respect of governance.

6.1.2 To assist the Board to fulfil this duty, the Board will receive:

- assurances of the strategic risks facing the Trust through the continued development of the Board Assurance Framework document
- summary upward reports from both the Quality and Safety Committee and Audit Committee (full minutes are available on request from the Company Secretary)
- all risk assessments categorised as 'red' (high scoring risks)
- monthly reports from the Director of Patient Care and Service Transformation and other Directors
- external assurance reports from the Care Quality Commission, NHSLA Risk Management Standards for Ambulance Trusts, the Health and Safety Executive, etc.,
- monthly Integrated performance report (IPR)/ Key performance indicator (KPI) reports.

6.2 Chief Executive

6.2.1 The **Chief Executive** has overall accountability for corporate governance and risk management. The Chief Executive will delegate specific areas of risk management responsibilities to each of the Executive Directors.

6.2.2 The Chief Executive is required to maintain the Trust's registration through the Care Quality Commission and an Annual Governance Statement in the Annual Report which states that they have confidence in the systems of control within the organisation.

6.3 Executive Directors

6.3.1 All Executive Directors have delegated responsibility for risk management and will:

- attend the Quality and Safety Committee, as appropriate, and will meet regularly with the Chief Executive (one-to-one performance meetings & Executive Team Meetings) to ensure that the strategic direction taken by the organisation is applicable to and takes into account each of the organisation's risk categories
- assess and decide upon the level of risk appetite for each of the strategic objectives
- champion the risk management process within their respective directorates
- in conjunction with the Chief Executive, ensure that the Trust's key risks are identified and addressed
- raise staff awareness, knowledge and skills and encourage their participation in risk management
- ensure that risk management is integrated within the strategic and operational planning and decision making throughout their directorates
- ensure that their respective Directorates contribute towards the effective management of risk, clinical governance and the fundamental standards of quality and safety.

6.4 Director of Patient Care and Service Transformation

6.4.1 The Director of Patient Care and Service Transformation has delegated responsibility for managing the strategic development and implementation of organisational risk management, clinical effectiveness and clinical governance.

6.4.2 The Director of Patient Care and Service Transformation's responsibilities include:

- coordinating and ensuring the implementation and continued development of risk management throughout the Trust
- communicating the Trust's commitment to the management of risk throughout the organisation
- being the Caldicott Guardian
- identifying and interpreting new legislation and Government guidance in relation to governance, health and safety and risk
- advising the Chief Executive, Directors and Board on matters of risk
- coordinating and obtaining assurances from each of the Executive Directors in relation to risk management and controls
- having effective arrangements in place for the receiving and monitoring all risk and adverse incident reports, identifying trends and produce statistical data for the Trust Board
- ensuring that the Trust has arrangements in place for the identification, investigation and management of all serious incidents requiring investigation (SIRI)
- ensuring that the Trust has a designated 'competent person' in relation to health and safety as required by regulation 7 of the 'Management of Health and Safety at Work Regulations 1999'
- acting as the Trust's designated Clinical Governance Co-ordinator, including implementing the Essential standards of quality and safety published by the Care Quality Commission
- acting as the Trust Executive lead for the following:
  - complaints and claims management
  - patient safety and quality
  - security management
  - patient experience and involvement
  - safeguarding of children and adults
  - control of infection and decontamination
  - medicines management.

6.5 Director of Finance

6.5.1 The Director of Finance has delegated responsibility for:

- managing the development and implementation of financial risk management, including risks associated with financial control, the detection and prevention of fraud and corruption, and Information Technology (IT) security.
- minimising corporate risks associated with all information, communication and technology systems. The post holder is responsible for electronic information security, and for the development and provision of robust IT, radio and communication systems which support the delivery and monitoring of the Trust's business objectives.

6.5.2 The Director of Finance also has responsibility for the management of the Trust's estate. These areas of responsibility are delegated through the IT Director and the Head of Estates who report to the Director of Finance.

6.6 Director of Human Resources

6.6.1 The Director of Human Resources has delegated responsibility for managing the strategic development and implementation of risk management associated with the employment of staff, with specific responsibility of recruitment and retention, and the delivery of the human resources function within the Trust.

6.7 The Chief Operating Officer

6.7.1 The Chief Operating Officer has delegated responsibility for managing the strategic development and implementation of clinical and non-clinical risk management, (Operational risks) associated with the provision of the Emergency service, call centres, Resource Centres. (Non-emergency services for transport are managed by the Director of Strategy, Business Development and Communications).

6.8 Operations Directors and the Commercial Director

6.8.1 Operations Directors and the Commercial Director have delegated responsibility for the development and implementation of effective risk management processes within their area of responsibility.

6.9 Medical Director

6.9.1 The Medical Director has delegated responsibility for the management of clinical standards. The Director also has responsibility for the national clinical performance indicators, pre-hospital clinical care, research and audit.

6.10 The Assistant Director of Quality

6.10.1 The Assistant Director of Quality will be responsible to the Director of Patient Care and Service Transformation for the development of effective Trust wide policies and procedures. Specific responsibilities will include monitoring all areas of risk management performance, maintaining and developing the Corporate Risk Register and acting as the point of reference within the Trust for all internal and external contacts in relation to all matters relating to risk management.

6.11 The Company Secretary

6.11.1 The Company Secretary will work closely with the Chairman, Chief Executive and

the Director of Patient Care and Service Transformation to co-ordinate the Trust Board and other relevant committees' agendas, ensuring that the Trust meets all legal, corporate and mandatory obligations.

6.12 Risk Department

6.12.1 The Risk Department will support the Assistant Director of Quality in managing risks at a Trust level. They will provide specialist advice and support to line managers and the Area Management team. They will undertake investigations, safety audits and inspections. The Head of Risk and Security is the Trust's designated 'competent person' in relation to health and safety as required by regulation 7 of the 'Management of Health and Safety at Work Regulations 1999'.

6.13 Head of Patient Experience

6.13.1 The Head of Patient Experience is responsible for coordinating the investigation and response to all complaints and compliments received by the Trust. They will monitor the pattern of complaints and ensure that learning points are identified and actioned.

6.14 Information Governance Manager

6.14.1 The Information Governance Manager will coordinate the annual Information Governance self-assessment and provide specialist advice in relation to Freedom of Information (FOI), Data Protection and Records Management. They will be responsible for the development and delivery of an annual improvement for information governance. They will also be the person who registers the Trust with the Information Commissioner's Office for data protection.

6.15 Divisional Director for Support Services

6.15.1 The Divisional Director for Support Services (including Equipment Lead) is responsible for the effective risk management of the Trust's Fleet operation including maintenance and repair of all Trust vehicles and maintenance and repair of equipment.

6.16 Driving Standards Manager

5.16.1 The Driving Standards Manager is responsible for vehicle accident management and investigation.

6.17 Head of Estates

6.17.1 The Head of Estates has responsibility for ensuring that all premises owned by the Trust, or any site where Trust staff are employed, are maintained to a standard that

is safe and is not likely to cause harm, injury or illness to anyone, staff or visitors, who may use such buildings at any point in the course of their work.

6.17.2 The Head of Estates has specific responsibility for fire protection and prevention, ensuring that the Trust fully complies with its statutory fire safety obligations. The Head of Estates will also advise on aspects of security relating to Trust premises.

6.18 Assistant Director of Education

6.18.1 The Assistant Director of Education has responsibility for ensuring that all mandatory training is identified and provided as required and for ensuring all education and training is delivered to a high standard. They will be responsible for ensuring that appropriate records are maintained of all training provided to staff, both internally and externally and/or sponsored by the Trust.

6.19 Non Executive designated 'Champions'

6.19.1 The Trust has appointed Non Executive leads to act as Board level 'Champions' for:

- Patient safety
- Security management

6.20 Managers and Supervisors

6.20.1 Managers and Supervisors are responsible for implementing and monitoring any identified and appropriate risk management control measures within their designated areas and scope of responsibility. In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, managers and supervisors are responsible for bringing these risks to the attention of their Executive or Area Director. They should also report the issue via the Trust's Incident reporting system, Datix and advise the Risk Department accordingly.

6.20.2 All Managers and Supervisors have a responsibility to undertake suitable and sufficient risk assessments as required, to supervise activities within their area of responsibility to ensure that policies and procedures are properly applied and that areas of risks are adequately controlled. In the event that a member of staff identifies a risk issue to them, they will investigate and carry out a suitable and sufficient risk assessment and, where necessary, implement appropriate further control measures to minimise that risk. Where the required action is outside or beyond their area or level or authority they will document their actions and recommendations before passing the matter to the next level of management for attention as per the Trust's Risk/Incident reporting procedures.

6.20.3 Trust Managers and Supervisors will:

- fully support the risk management process within their Directorates
- ensure that their department as a whole is effective and efficient in the management of actual and potential risks
- ensure that Trust decisions in relation to risk management are carried out and all relevant policies and procedures are implemented and monitored.

6.21 All staff

6.21.1 All Trust employees will:

- participate, whenever required, in the risk assessment and risk management process
- comply with all Trust Policies and Procedures
- work professionally in accordance with the Trust and, where appropriate, respective professional Codes of Conduct
- work safely in compliance with Section 7 of the Health and Safety at Work etc Act 1974
- not intentionally or recklessly interfere with or misuse any equipment provided for the protection of safety and health (Section 8 Health and Safety at Work etc Act 1974)
- report any identified areas of risk immediately or within 24 hours in accordance with the Trust's Risk/Incident reporting procedures and regulation 14 of the Management of Health and Safety at Work Regulations 1999
- provide safe clinical practice in diagnosis and treatment in accordance with protocols
- be aware of emergency procedures e.g. resuscitation, evacuation and fire precaution procedures appertaining to their particular Resource Centre, department or location
- report concerns regarding fraud, theft or other misappropriation of Trust funds or assets
- report concerns regarding malpractice or mistreatment of patients by colleagues
- undertake mandatory health and safety and other risk assessment and risk management training as required by the Trust.

7. Definitions

Hazard	Something that has the potential to cause injury, loss, damage or harm.
Risk	The likelihood that the identified hazard will occur resulting in injury, damage, loss or harm.
Risk Assessment	The systematic process by which hazards and any associated controls are identified and the risks are evaluated and rated using tools implemented by the Trust for use by all employees. Assessments can either be general or specific, but will be undertaken by competent persons who have received the appropriate degree of information, instruction and training.

Risk Management	The identification, quantification, control, mitigation, review and audit of any risk that threatens the services delivered or assets of the Trust. This shall include such diverse aspects as health and safety, clinical care and patient experience, property, vehicles and equipment, environment and relationships with stakeholders.
Risk appetite	The risk appetite is the amount and type of risk that the Trust is prepared to take or tolerate to achieve its strategic objectives. The Trust can have a range of different risk appetites depending on the nature of the objective.
Risk Matrix	The tool that is used to "score" each risk and determine its place on the Corporate Risk Register. The levels and type of risk are determined through the use of this matrix and this will provide a priority list for managers to use within their respective area of control.
Corporate Risk Register	The register is the recording tool for all identified risks and will be held centrally, maintained by the Assistant Director of Quality, supported by the Risk Department. The register will also record risk identified through the Assurance Framework.
Acceptable Risk	The Trust Board accepts that no system can be totally risk free and that there are occasions when the Trust will have to accept a degree of risk in the course of its undertakings. Work practices, procedures, hazardous chemicals, equipment and the environment will be assessed so as to identify the significant hazards and risks and ensure that controls are implemented to eliminate or reduce the risks to the lowest reasonably practicable level.
Organisational Risk	Any potential threat or occurrence that could prevent the Trust from delivering its aims, achieving its objectives or developing projects to improve its services within the economic, human, environmental and technological boundaries.
Clinical Risk	Any potential threat or occurrence related to the diagnosis, treatment and/or outcome of patient care where the likelihood is that the identified hazard causes harm or distress to the patient.
Financial Risk	Any potential threat or occurrence that could prevent the Trust from effectively managing its finances, meeting its statutory financial duties and operating within the appropriate control systems.
Near Miss	Any general, clinical or financial incident which has the potential to prevent the Trust from delivering on its objectives, notwithstanding the fact that no adverse consequences occurred from the specific incident.
Significant Lapse	The Trust's definition of a 'Significant Lapse' "is any area which, following a risk assessment, score a risk rating of 15 and above" See the Trust's Position Statement process.

8. Committee Structure

8.1 The Trust's risk management performance will be reported to the Board through the

Quality and Safety report.

8.1.1 The Trust Board have agreed a number of sub-committees, and working groups which report to the Board on organisational matters (See Appendix 2, Board Committee Structure). Terms of Reference for each of these Committees/Working Groups are held centrally and reviewed on an annual basis at the first meeting of each new financial year. Summaries of Committee meetings are included in the Board papers, circulated to all Directors prior to Board meetings. It is the responsibility of each Committee Chair to apprise the Board of any significant issues to note from the summary upward report.

8.2 Quality and Safety Committee

8.2.1 This Committee monitors and reviews on behalf of the Board the Trust's Clinical Governance arrangements which include co-ordinating and prioritising clinical and non-clinical risk management issues. It specifically conducts deep dive reviews into quality and clinical risks and monitors performance with regards to risk assessments and the Corporate Risk Register; Complaints/Patient experience issues; Legal claims; Health and safety; Adverse incidents; Serious incidents requiring investigation; Risk reports; Quality; and Clinical performance and improvement.

8.3 Audit Committee

8.3.1 This Committee is primarily concerned with corporate and financial risks but also has the remit to monitor the Trust's corporate and clinical governance controls which includes risk management performance against the Trust's Board Assurance Framework and risk register action plans.

8.3.2 The Committee receives external and internal audit reports and will approve the Trust's draft Annual Governance Statement. The Audit Committee agrees the Internal Audit Plan for the Trust which includes assessment of the Trust in the three core areas of the Controls Assurance plan i.e. Governance, risk management and financial management. The Audit Plan for 2018/19 also includes an audit of the degree in which the Trust has embedded the Board Assurance Framework. The Annual Audit report is agreed by the Audit Committee. The Audit Committee ensure that all aspects of quality are covered by the relevant committees.

8.4 Executive Team

8.4.1 The Executive Team will receive and review updates from all Directorates relating to risk management, or related governance issues. The Executive Team Meetings and the monthly one-to-one performance meetings with the Chief Executive ensures that the strategic direction taken by each Directorate is applicable to the Trust's overall business plan and takes into account risk associated with new initiatives.

8.5 Area Management Team

8.5.1 The Area Management Team (operations) will meet at least monthly to monitor

performance related issues, including safety and risk issues. The meeting will be chaired by the Operations Directors and attended by local Managers and a representative of the Risk Department.

8.6 The Serious Incident Requiring Investigation (SIRI) Review Group

8.6.1 The Serious Incident Requiring Investigation (SIRI) Review Group reports to the Executive Management Committee and reviews all serious incidents and associated investigation reports which are reported to and shared with the appropriate CCG. The Serious Incident Requiring Investigation Review Group meets every six weeks or less (where applicable) and examines and reviews investigation reports and identifies any trends and management actions in order to improve patient care.

8.7 Health, Safety & Risk Group

8.7.1 The Trust's Health Safety & Risk Group is a statutory committee under current Health and safety legislation. It provides a forum for Safety Representatives, Staff Representatives and specialist Managers to meet to discuss and monitor issues associated with health and safety, welfare and risk management, including infection control and to recommend changes or improvements to the Executive Team and Quality and Safety Committee. This Group reports to the Board through the Executive Management Committee. See Terms of Reference.

8.8 Patient Safety Group

8.8.1 The Patient Safety Group is a sub group of the Executive Management Committee and will review the clinical activity provided by the Trust and ensure that all underlying processes fully support staff to provide high quality / safe patient care. This includes monitoring the effectiveness of safeguarding of children and adults, clinical audit, safe administration of medicines, all grades of clinical incidents and learning following investigations and infection prevention and control.

8.9 Patient Experience Review Group

8.9.1 The Patient Experience Review Group is a sub group of the Quality and Safety Committee chaired by the Chief Executive. This group will meet quarterly and review the handling and investigation of complaints. It will identify trends and monitoring action plans and performance.

8.10 Equipment, Vehicle Review Group

8.10.1 The Equipment, Vehicle Review Group will report to the Health, Safety and Risk Group. The Group will review all incidents involving Trust vehicles and monitor the reporting, actions and training outcomes. Minutes of this meeting will be

forwarded to the Health, Safety and Risk Group.

8.11 Specialist Infection Control Advice

8.11.1 The Trust commissions, under a Service level agreement, external specialist advice. This will be provided by an expert in infection control matters and may be a Nurse or Doctor with specialist training in this field. The special advisors report to the Patient Safety Group as appropriate. The Board will ensure that adequate finance is made available to commission this service.

8.12 Occupational Health

8.12.1 The Trust will commission Occupational Health Services to provide for the health and well-being of all SCAS staff. Such services will include pre and post-employment medical screening, vaccination programmes, confidential health assessment and advice, including risk assessment and advice following exposure to infection.

9.0 Risk Management Tools

9.1 The Trust will continue to utilise a range of risk management tools to identify and control risks, these include:

- risk assessment and the risk assessment process
- Corporate risk register, Directorate risk registers and specific Meeting Group's risk registers
- the monthly Integrated Performance Report (IPR)
- bi-monthly/quarterly review of adverse incident / accident reports looking for patterns of frequency or cause
- quarterly review of claims and complaints performance
- workplace inspections
- annual fire safety inspections
- annual review of performance against the NHSLA Risk Management Standards for Ambulance Trusts
- annual self-assessment against Care Quality Commission Essential Standards of quality and safety.

9.2 Assessment and Acceptability of Risk

9.2.1 In accordance with governance best practice and legislative requirements the Trust will formally risk assess and record all significant risks. The Assistant Director of Quality will maintain the Corporate Risk Register on behalf of the Director of Patient Care and Service Transformation.

9.2.2 The Trust's aim is that the carrying out of suitable and sufficient risk assessments should become an integral part of everyday activity, becoming a pre-emptive approach to reducing accidents and adverse incidents rather than being reactive. With this aim in mind Directors and managers must consider the potential risks

involved in all activities and particularly so for any new initiative, activity or plan.

9.2.3 A suitable and sufficient risk assessment must be completed for all risks identified within the Trust. All completed generic risk assessments will be in writing and recorded on the Trust's generic risk assessment form (See Appendix 1) and submitted to the Assistant Director of Quality and the Risk Department. Risk assessments with a score of amber or above will be passed to the Executive Team for consideration. These risk assessments will be discussed by the Executive Directors and a decision taken as to the acceptability of the risk and the recommended control measures / actions.

9.2.4 Any manager may complete a risk assessment either in response to an untoward incident, an identified hazard/risk or as part of a business case for a new development, service or programme. The latter approach will be particularly encouraged to develop a pro-active method of risk management best practice.

9.2.5 Risks will be graded according to the Risk assessment matrix, (See Appendix 1). When grading risk, the Risk Descriptor Table should be used (See Appendix 1 A) For further details of what action should be taken, see the Risk Assessment Matrix Actions Table in Appendix 1.

9.2.6 Those in the yellow (moderate) and amber (significant) risk grading will receive priority relevant to their score. Such risks will generally be managed at Area level.

9.2.7 Risk in the green sector is considered to be low risk, and whilst the Trust will endeavour to minimise these they will be of low priority.

9.2.8 All risk assessments will be subject to ongoing review. The Assistant Director of Quality will maintain an action plan of all outstanding actions arising from the Corporate risk register. The Quality and Safety Committee and the Audit Committee will review the risk register at every meeting. The Executive Team will review this on a quarterly basis for progress.

9.2.9 For root cause analysis and investigations on adverse incidents see section 7.0 and Appendix 5 of the Adverse Incident Reporting and Investigation Policy.

10. Corporate Risk Register

10.1 The Trust has a Corporate risk register that contains all of the high level (red) risks from each of the Directorate risk registers and other risk registers within the Trust. The Corporate risk register is reviewed by the Executive Management Committee and the Trust Board.

10.2 Each of the Directors and Associate Directors can as the respective chairs of various Trust Forums report high level (red) risks up for inclusion onto the Corporate risk register.

11. Directorate and other Risk Registers

11.1 There are a number of Directorate risk registers and these are managed and maintained by each respective Directorate on either a monthly or bi-monthly basis.

11.2 There are also other risk registers such as the Health, Safety and Risk Group risk register and these are managed and maintained on either a monthly or bi-monthly basis by the respective Trust forums that they are presented and reviewed at.

11.2 When they review their risk registers the Directorates and the respective Trust forums can either add or remove risks and can also increase or reduce the risk score depending on the level of risk and the measures taken to manage, control or reduce the risk score.

12. Board Assurance Framework and Annual Governance Statement

12.1 The Board Assurance Framework is a high level management assessment process to ensure delivery of the key strategic objectives. The Assurance Framework will cover all of the Trust's main activities, identifying any risks that may prevent the achievement of the set objectives and targets. It will identify and examine the system of governance in place to manage these risks. It will also identify and examine the assurances in place to check the effectiveness of this governance. These assurances may derive from internal or external sources such as monitoring against key performance targets or establishing effective reporting mechanisms within the Trust to the Trust Board.

12.2 Any gaps in the identification of effective controls and assurances to manage or prevent a risk must be recorded and acted upon by the Trust Board. Updates on the Assurance Framework will be presented to the Audit Committee and Trust Board on a bi-monthly basis.

12.3 The management of risk is integral to the performance of the Trust in realising its objectives as such there is a strong interface between the Assurance Framework and the Corporate Risk Register (see Appendix 3).

12.4 The Chief Executive, as the accountable officer for the organisation, has overall responsibility for its risk management regime. The effective discharge of this responsibility will be reported in the annual Governance statement and published in the Trust's Annual report.

13. Communicating Risk and Engaging Staff

13.1 In order to achieve successful risk management it is essential that all levels of the organisation are informed and engaged. The Trust communicates with stakeholders and staff through the Trust's website, e-mail, publications and line managers. Only then can it be said that the Trust has a positive risk aware culture.

13.2 In order to achieve this aspiration the Trust has clearly stated both in this strategy and on all training courses its commitment to a fair blame culture.

13.3 In order to assist managers in investigating untoward incidents the Trust has made available to all managers the NHSi incident decision tree.

13.4 The Trust will be open about adverse incidents sharing learning with staff, health

partners and patients and, where necessary, the patient's representatives.

13.5 The Head of Risk and Security will issue risk information notices to draw to the attention of staff any significant safety issues or issues notified through the electronic Central Alerting System (CAS).

13.6 All new policies and procedures are distributed as 'all recipient' e-mails. Policies are available to all staff on all Trust premises and are available via the Trust's intranet and internet web- sites.

14. Training and Education

14.1 It is essential that all staff receive such training and awareness of health and safety and risk management as is relevant to their area of work. Such training may take place in a formal environment i.e. a classroom or be work-based and also through technology enhanced learning e.g. e learning, podcasts and videos.

14.2 Satisfactory completion of training will be recorded in the member of staff's learning record. Training records will be held on the member of staff's training file.

14.3 It is the responsibility of the line manager to ensure that all statutory and mandatory training is undertaken and the Assistant Director of Education is responsible for ensuring records of training are kept and that systems are in place to identify to line managers those who have not completed their training.

14.4 The Trust provides Root cause analysis/Serious Incident investigation training using some of the National Patient Safety Agency (NPSA) programme and Managing Safely Training accredited through the Institute of Occupational Safety and Health (IOSH) to all its managers as part of individual performance development Training (IPD).

14.5 The Education Review Group reviews the training needs analysis annually taking into consideration risk assessments and the trends analysis of key performance indicators (KPIs) that it receives at each meeting.

14.6 The results of the training needs analysis are used to inform the Trust's Training Programme.

14.7 The Trust recognises the importance of training and education to increase awareness of risk and safety issues. All staff will receive the statutory and mandatory training as described in the relevant Statutory and Mandatory Training policy.

15. Equality and Diversity

15.1 An equality and diversity impact assessment has been carried out on this strategy and can be found at appendix 5.

16. Monitoring

16.1 The effectiveness of this strategy will be monitored in the following way:

Standard / process / issue	Monitoring and audit			
	Method	**By**	**Committee**	**Frequency**
a) The number and percentage of staff completing mandatory and induction training in year.	a) Report from Education and Training.	a) Head of Education and Training/ Assistant Director of Quality.	Executive Management Committee. Audit Committee.	Monitored every six months, but audited and reported on annually, as a minimum.
b) The number of incidents reported through the Whistleblowing policy.	b) Report from Human Resources.	b) Director Human Resources. Assistant Director of Quality.		
c) The number of adverse incidents, serious incidents requiring investigation, duty of candour incidents, patient experience issues/complaints and claims reported and the time taken to complete along with the outcome and learning of these incidents and the pathway which a claim arose from.	c) Report from Risk, Patient Experience and Claims.	c) Heads of Risk, Patient Experience and Claims.		
d) The number of root cause analysis investigations performed on adverse incidents, complaints, claims and serious incidents requiring investigation and the reported outcomes.	d) Report from Risk, Patient Experience and Claims.	d) Heads or Risk, Patient Experience and Claims. e) Head or Risk and Security.		

e) The number of reported incidents, serious incidents requiring investigation reported to external agencies (NPSA, Monitor, the Health and Safety Executive and NHS Protect).	e) Report from Risk.			
f) The proportion of identified control measures that have been actioned against risks identified through incident investigation (monitored through risk register review).	f) Report from Assistant Director of Quality.	f) Assistant Director of Quality.		
g) The monitoring of attendance of managers at committees and groups.	g) Report from relevant Groups and Internal Audit Committees.	g) Assistant Director of Quality.		

17. Consultation and Review

17.1 A consultation exercise on the strategy will be carried out with the stakeholders listed below.

17.2 This strategy will be reviewed annually or sooner if there are any relevant changes to legislation or best practice.

18. Implementation (including raising awareness)

18.1 The strategy will be implemented and communicated to managers and staff within the Trust via the weekly newsletter, Staff Matters.

18.2 Emails will also be sent to senior managers and area managers asking them to bring the existence of the strategy to their staff.

19. References

- Health and Safety at Work Act 1974
- The Care Act 2014
- Equality Act 2010
- Data Protection Act 1998

This list is not exhaustive.

20. Associated documentation

- CQC Fundamental Standards
- Adverse Incident Reporting and Investigation Policy
- Board Assurance Framework
- Health & Safety Policy and Procedures
- Infection Prevention, Control & Decontamination Policy and Procedures
- Central Alerting System
- Statutory and Mandatory Training Policy
- Patient and Public Experience Policy
- Duty of Candour policy
- Claims Management Policy
- Whistleblowing Policy
- Corporate Risk Register
- TOR Quality and Safety Committee
  TOR Audit Committee
- TOR Clinical Review Group
- TOR Operational Health, Safety and Risk Group
- Patient Experience Review Group
  TOR Serious Incident Review Group
  Committee / Meeting Structure

21. Review Table

Version	Reason for change	Overview of change
V10	Review of policy	Adoption of new policy template. Section 1.1: Removal of reference to Milton Keynes and inclusion of reference to Surrey and Sussex. Removal of reference to residential population and geographical area the Trust covers. Section 3: Insertion of the Equality Statement. Section 5.2 insertion of bullet points about the Integrated Performance

		Report; and risk assessment training to managers and staff. Insertion of reference to Trust's risk appetite (section 6.3.1). Insertion of section 6.7.2 on Chief Operating Officer being the CEO of SCFS Ltd. Section 6.1.4: Insertion of reference to Information Commissioner's Office and data protection. Insertion of definition of risk appetite (section 7 - Definitions). Change of frequency of SIRI Review group meetings from bimonthly to every six weeks and less (where applicable) (section 7.6.1). Insertion of section 8.3 about South Central Fleet Services (SCFS) Ltd. Section 9, addition of bullet points on risk assessments and risk management process; Corporate, Directorate and other risk registers; and bi-monthly/quarterly review of incident reports. Change Director of Patient Care and Quality to Director of Patient Care and Service Transformation throughout the document. Reference to Trust's risk appetite (section 9.2.5). Insertion of section 10: Corporate risk register. Insertion of section 11: Directorate and other risk registers. Change to monitoring section, stating who will provide reports and to whom (section 16). Insertion of Health and Safety at Work Act 1974; The Care Act 2014; the Equality Act 2010 and the Data Protection Act 1998 in section 19 - References.

		Insertion of Whistleblowing Policy in section 20 – Associated Documentation.

Appendix 1

South Central Ambulance Service NHS Foundation Trust Generic Risk Assessment Form							
Risk assessment on (Task/Activity/Environment, etc.,):							
Person (s) carrying out the assessment:			**Department/Area/Directorate:**				
Risk assessment number:		**Date of assessment:**		**Date of review of assessment:**			
Ref	**Hazards** (List all of the identified hazards)	**Existing Controls** (List all of the measures currently in place to control exposure to the hazards)	**Initial risk score (SxL =)**	**Further controls required- Action Plan** (List all of the additional measures to be introduced to reduce the risk to the lowest level reasonably practicable)	**To be Completed by:** (Insert name of person)	**When** (insert date when further controls will be completed)	**Final risk score (SxL=)**
1.							
2.							
3.							

Appendix 2

Risk Assessment Matrix					
	Likelihood				
Consequence	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
Insignificant (1)	1	2	3	4	5
Minor (2)	2	4	6	8	10
Moderate (3)	3	6	9	12	15
Major (4)	4	8	12	16	20
Catastrophic (5)	5	10	15	20	25

Risk Rating Key

1 – 3	Low risk
4 - 6	Moderate Risk
8 - 12	Significant Risk
15 – 25	High risk

Risk Assessment Matrix Actions			
Category	**Investigation**	**Analysis**	**Outcome**
Red (High)	• Full investigation by local/duty manager • Executive Director notified by telephone	• Full Root Cause Analysis • Refer to Exec Team • Refer to QSC • Board informed	• Immediate control measures implemented • Long term improvement strategy developed
Amber (Significant)	• Full investigation by local/duty manager • Executive Director notified within 24 hours or by telephone if appropriate	• Consider Root Cause Analysis • Refer to Exec Team • Refer QSC	• Planned implementation of control measures
Yellow (Moderate)	• Investigation by local manager	• Trends monitored	• Where possible risk reduction measures introduced
Green (Low)	• Minimal investigation	• Trends monitored	• Minimal action

South Central Ambulance Service NHS Foundation Trust

Appendix 3

South Central Ambulance Service NHS Foundation Trust – Risk Descriptor Table

Consequence/Impact Score

	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Injury **(Physical & Mental)** **to anyone**	Minor injury (not requiring first aid)	Minor injury or illness (first aid treatment needed)	Reportable to external agencies/statutory bodies (e.g. RIDDOR, HSE, NPSA, Police, MHRA, SHA)	Major injuries, or long term incapacity / disability (loss of limb)	Death or major permanent incapacity
Patient Experience	Unsatisfactory patient experience no injury	Unsatisfactory patient experience and or involving first aid treatment – readily resolvable	Mismanagement of patient care requiring more than first aid treatment and is likely to take more than one month to recover (breach of working practices)	Serious mismanagement of patient care (major permanent harm) (breach of working practices)	Totally unsatisfactory patient care (breach of working practices)
Complaint / Claim Potential	Locally resolved complaint	Justifiable complaint peripheral to clinical care / management	Justifiable complaint involving lack of appropriate care / management Claim below excess	Multiple justifiable complaints. Claim above excess	Multiple claims or single major claim
Objectives / Projects	Insignificant cost increase / schedule slippage Barely noticeable reduction in scope or quality	< 5% over budget / schedule slippage Minor reduction in quality or scope	5 – 10% over budget / schedule slippage Reduction in scope or quality requiring client approval	10 – 30% over budget / schedule slippage Does not meet secondary objective(s)	> 30% over budget / schedule slippage Does not meet primary objective(s)

Service / Business Interruption	Loss / interruption < 1 hour	Loss / interruption >1 hour and < 8 hours	Loss / interruption > 8 hours and < 24 hours	Loss / interruption > 24 hours and < 1 week	Loss / interruption > 1 week
Human Resources / Organisational Development	Short term low staffing level temporarily reduces service quality < 1 day	Ongoing low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Minor error due to insufficient training. Ongoing unsafe staffing level(s)	Uncertain delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Serious error due to insufficient training	Non delivery of key objective / service due to lack of staff. Very high turnover. Critical error due to insufficient training
Financial	<0.1% of budgeted income	>0.1% and <0.25% of budgeted income	>0.25% and <0.5% of budgeted income	>0.5% and<1.5% of budgeted income	>1.5% of budgeted income
Inspection / Audit	Minor recommendations Minor non-compliance with standards	Recommendations given Non-compliance with standards	Reduced rating Challenging recommendations. Non-compliance with core standards Reportable to associated external / statutory agencies	Enforcement action Low rating. Critical report. Multiple challenging recommendations. Major non-compliance with standards	Prosecution Zero rating. Severely critical reports.
Adverse Publicity / Reputation	Rumours	Local Media interest (short term)	Local Media interest (long term)	National Media interest < 3 days. Local MP concern	National Media interest > 3 days. National MP concern (questions in the House)

Appendix 4

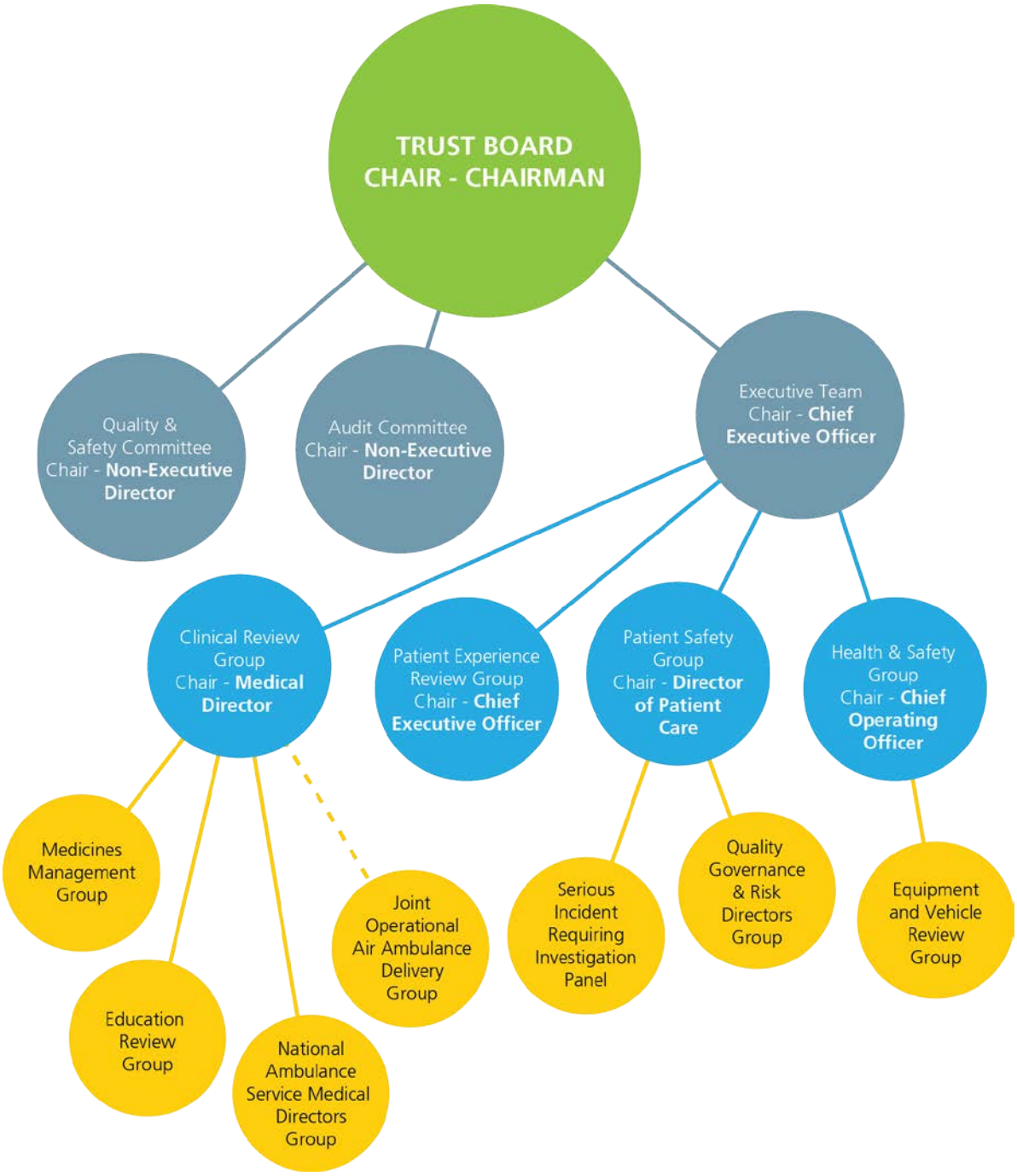
South Central Ambulance Service NHS Foundation Trust – Risk Scoring System

Likelihood Score

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur annually	Expected to occur at least annually	Expected to occur at least every 6 months	Expected to occur at least monthly	Expected to occur at least weekly
Probability	< 1%	1 – 5%	6 – 25%	26 – 60%	> 60%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

Appendix 5

South Central Ambulance Service NHS Foundation Trust Board Committee Structure



Appendix 6

Board to Road/Floor Visibility of Risk Management Process Outline

Report	Purpose	Reviewed by	Frequency	Sourcing Risk from:
Board Assurance Framework	Identify, assess and manage all risks to the Trust's strategic objectives Delegate sub-committees with responsibility for managing and tracking actions Feed all risks rated as 15 or more and/or have a consequence of 5 into the Corporate Risk Register Address any risks flagged as RED	Board & Board committees	Board - Bi-monthly Sub Committees - In line with committee cycle	Board discussion, Monitor, Quality Assurance Framework, Leadership Walkarounds Escalation from sub-committees Performance data (IPR) Compliance Reporting (CQC, NHSLA, Audit, NICE Guidelines Compliance etc) Trust wide risk assessments/Clinical Audits Patient & Staff Experience Surveys
Risk profile summary	Receive and manage exceptions from the Corporate Risk Register (new risks, increased risks, actions outstanding, risks which remain RED)	Board	Quarterly	Corporate Risk Register and BAF
Corporate Risk Register	Identify, assess and manage all risks across the Trust Accept risks and associated actions where these are rated 15 or more Report and manage exceptions (new risks, increased risks, actions outstanding, risks which remain RED) Address any risks flagged as RED	ED's	Bi-monthly	Committee discussion, Serious Incident Review Group Escalation from sub-committees and operational service team meetings Performance data Compliance Reporting (CQC, NHSLA, Audit, NICE Guidelines Compliance etc) Reporting (Complaints, Litigation, Incidents & PALs) Risk Assessments Patient & Staff Experience Surveys

Other SCAS Risk Registers - IM&T. H&S, HR	Identify, assess and manage all risks across the responsibility Accept risks and associated actions where these are rated less than 15 Escalate risks and recommended actions where these are rated 15 or more Submit Register to ADQ quarterly Address any risks flagged as RED	Corporate teams, Area Directors and ED's	Team discussion - Monthly Submission of refreshed register - Quarterly	Management, operational and clinical team discussion Performance data Clinical Audit Compliance Reporting (CQC, NHSLA, Audit, NICE Guidelines Compliance etc) Reporting (Complaints, Litigation, Incidents & PALs) Risk Assessments Patient & Staff Experience Surveys

Appendix 7

Responsibility Matrix – Policies, Procedures and Strategies

Policy Group	Lead Director / Officer	Working Group	Committee	Board Ratification
Strategies	As appropriate	As appropriate	As appropriate	Required
Standing Orders & Standing Financial Instructions	Chief Executive + Director of Finance	Not applicable	Audit Committee	Required
Corporate Policies	Chief Executive +Director of Patient Care and Service Transformation	As appropriate	Quality and Safety Committee	Required/ Committee decision
Health and Safety Policies and Procedures	Director of Patient Care and Service Transformation	Strategic Health, Safety and Risk Group	Quality and Safety Committee	Health and Safety Policy – Required H&S Appendices – Committee decision
Infection Prevention, Control & Decontamination Policy & Procedures	Director of Patient Care and Service Transformation	Clinical Review Group	Quality and Safety Committee	Required
Personnel Policies and Procedures	Human Resources Director	Staff Consultation Group	Quality and Safety Committee	Required for new policies. Committee decision for revisions
Financial Policies and Procedures.	Director of Finance	Not applicable	Audit Committee	Required for new Policies. Committee decision for procedural changes.
Operational Policies and Procedures	Chief Operational Officer	As appropriate or through Team Meeting	Quality and Safety Committee	Committee decision
Information and IM & T Policies and Procedures	Director of Information Management & Technology (IM & T).	IM & T Control Board	Audit Committee	Committee decision
Emergency Operational Centre Policies and Procedures	Chief Operational Officer	As appropriate	Quality and Safety Committee	Committee decision
Clinical Policies and Procedures	Director of Clinical Services	Clinical Review Group	Quality and Safety Committee	Committee decision

Appendix 8

Equality Impact Assessment Form Section One – Screening

Name of Function, Policy or Strategy: Risk Management Strategy

Officer completing assessment: John Dunn, Head of Risk and Security.

Telephone: 07788 584786.

1. What is the main purpose of the strategy, function or policy?
To assist the Trust with the management of risk.
2. List the main activities of the function or policy? (for strategies list the main policy areas)
The aims of this strategy are to: • integrate risk management into the Trust's culture and everyday management practice • clearly define the Trust's approach and commitment to risk management • raise staff awareness, knowledge and skills • document responsibilities and a structure for managing risk • ensure a co-ordinated, standard methodology is adopted by every directorate/ department • encourage and support incident reporting in a 'fair blame' culture • ensure that the Trust Chief Executive and Trust Board are provided with evidence that risks are being appropriately identified, assessed, addressed and monitored • adopt an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety or financial risk, through the processes and structures detailed in this strategy • accept that whilst the provision of health care is not risk free, the Trust will aim to minimise the adverse effects of any risks • to manage risk via the Quality and Safety Committee and Audit Committee both of which are a sub committees of the Trust Board • manage risk as part of normal line management responsibilities and provide funding to address 'risk' issues as part of the normal business planning process • undertake suitable and sufficient risk assessments • ensure the Trust fulfils its legal and governance responsibilities • to preserve and enhance the Trust's reputation • to protect the assets and interests of the Trust • to protect the interests of staff, stakeholders, patients and the public (i.e. all those affected by Trust business).
3. Who will be the main beneficiaries of the strategy/function/policy?
All Managers and staff within the Trust.
1. Use the table overleaf to indicate the following:-

a. Where do you think that the strategy/function/policy could have an adverse impact on any equality group, i.e. it could disadvantage them?

b. Where do you think that there could be a positive impact on any of the groups or contribute to promoting equality, equal opportunities or improving relations within equality target groups?

		Positive Impact	Negative Impact	Reasons
GENDER	Women	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.
	Men	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.
RACE	Asian or Asian British People	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.
	Black or Black British People	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.
	Chinese people and other people	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.
	People of Mixed Race	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.
	White people (including Irish people)	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.
DISABILITY	Disabled People	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.
SEXUAL ORIENTATION	Lesbians, gay men and bisexuals	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.
AGE	Older People (60+)	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.
	Younger People (17 to 25) and children	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.

RELIGION/BELIEF	Faith Groups	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.
	Equal Opportunities and/or improved relations	✓	N/A	The strategy is designed to apply equally to all managers and staff within the Trust.

Notes:

Faith groups cover a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and to the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

5. If you have indicated that there is a negative impact, is that impact:		
	Yes	**No**
Legal (it is not discriminatory under anti-discriminatory law)		✓
Intended		✓
	High	**Low**
Level of Impact		✓
If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.		
6(a). Could you minimise or remove any negative impact that is of low significance? Explain how below:		
6(b). Could you improve the strategy, function or policy positive impact? Explain how below:		
7. If there is no evidence that the strategy, function or policy promotes equality, equal opportunities or improves relations – could it be adopted so it does? How		
Please sign and date this form, keep one copy and send one copy to the Trust's Equality Lead.		
Signed: ……		
Name: John Dunn, Head of Risk and Security.		
Date: 5/5/18.		

Appendix 6: Equality Impact Assessment Form Section Two – Full Assessment

Name of Function, Policy or Strategy: Risk Management Strategy.

Officer completing assessment: John Dunn, Head of Risk and Security.

Telephone: 07788 584786.

Part A

Looking back at section one of the EqIA, in what areas are there concerns that the strategy, policy or project could have a negative impact?

Gender	☐
Race	☐
Disability	☐
Sexual Orientation	☐
Age	☐
Religion/Belief	☐

2. Summarise the likely negative impacts:-

.....

.....

.....

3. Using the table below, give a summary of what previous or planned consultation on this topic, policy, function or strategy has or will take place with groups or individuals from the equality target groups and what has this consultation noted about the likely negative impact?

Equality Target Groups	Summary of consultation planned or taken place
Gender	

Race	
Disability	
Sexual Orientation	
Age	
Religion/Belief	

4. What consultation has taken place or is planned with Trust staff including staff that have or will have direct experience of implementing the strategy, policy or function?

.....

.....

5. Check that any research, reports, studies concerning the equality target groups and the likely impact have been used to plan the project and guide or indicate what research you intend to carry out:-

Equality Target Groups	Title/type of/details of research/report
Gender	
Race	
Disability	
Sexuality Orientation	
Age	

Religion/Belief	

6. If there are gaps in your previous or planned consultation and research, are there any experts/relevant groups that can be contacted to get further views or evidence on the issues?

☐ Yes (Please list them and explain how you will obtain their views)

.....

.....

☐ No

Part B

Complete this section when consultation and research has be carried out

7a. As a result of this assessment and available evidence collected, including consultation, state whether there will be a need to be any changes made/planned to the policy, strategy or function.

7b. As a result of this assessment and available evidence is it important that the Trust commission specific research on this issue or carry out monitoring/data collection?

(You may want to add this information directly on to the action plan at the end of this assessment form)

.....

.....

.....

.....

8. Will the changes planned ensure that negative impact is:

Legal? ☐

(not discriminatory, under anti-discriminatory legislation)

Intended? ☐

Low impact? ☐

9a. Have you set up a monitoring/evaluation/review process to check the successful implementation of the strategy, function or policy?

Yes ☐ No ☐

9b. How will this monitoring/evaluation further assess the impact on the equality target groups/ensure that the strategy/policy/function is non-discriminatory?

Details:

.....

.....

.....

.....

Please complete the action plan overleaf, sign the EQIA, retain a copy and send a copy of the full EQIA and Action Plan to the Trust's Equality Lead.

Signed:.....

Name:.....

Date:.....

EQIA ACTION PLAN

Issue	Action Required	Lead Officer	Timescale	Resource Implications	Comments

Please continue on another sheet if you need to.

.

Ratification Checklist

Section 1: To be completed by Author prior to submission for ratification

Policy Title	Risk Management Strategy
Author's Name and Job Title	John Dunn, Head of Risk and Security
Review Deadline	February 2019
Consultation From – To (dates)	
Comments Received? (Y/N)	
All Comments Incorporated? (Y/N)	
If No, please list comments not included along with reasons	
Equality Impact Assessment completed (date)	Completed February 2018
Name of Accountable Group	Executive Management Committee
Date of Submission for Ratification	

Section 2: To be completed by Accountable Group

Template Policy Used (Y/N)	Y
All Sections Completed (Y/N)	Y
Monitoring Section Completed (Y/N)	Y
Date of Ratification	
Date Policy is Active	
Date Next Review Due	
Signature of Accountable Group Chair (or Deputy)	
Name of Accountable Group Chair (or Deputy)	